CITY OF FAIRFAX FIRE DEPARTMENT
EMS FEE FOR TRANSPORT PROGRAM

Request for Transport Fee Hardship Waiver

A NEW HARDSHIP APPLICATION MUST BE SUBMITTED FOR EACH EMS TRANSPORT

Patient Name: _____ SSN: _____

Patient Address: _____

City, State and Zip: _____

Patient Phone: _____ Patient Alternate Phone: _____

Patient Date of Birth: _____ EMS Transport Date: _____

Monthly Household Gross Income: _____ Number of dependents living in household: _____

List of attached documentation: _____

_____

Responsible Party (if different from patient)

Name: _____ Relationship: _____

Address (if different from patient): _____

City, State and Zip: _____

I do herby request that I, as either the applicant, or the party who is financially responsible for the applicant, be considered for a reduction in the payment responsibilities as they relate to this EMS transport service fee. ***By signing this form I certify that I have no insurance that can be billed for this charge or the remaining balance after primary insurance payment.*** I declare that all of the information contained in this document and the attachments are true and accurate. Further I understand that I may be held liable for any false statements pertaining to this waiver request. I herby agree to notify the City of Fairfax of any change in the financial status of the applicant or the responsible party that may affect the ability to pay the EMS Transport Fee.

_____ _____
Signature Date

_____
Print Name

For questions regarding the hardship waiver process call 703-385-7940 or via e-mail to emsbilling@fairfaxva.gov

Mail this application and all attachments to:

City of Fairfax EMS Billing
4081 University Drive
Fairfax, VA 22030

Administrative Use Only

Incident #: _____ Date Received: _____
Account #: _____ Vendor Notified: _____
Claim: (circle) Approved Denied Reason: _____

_____

Date Approved: _____ Approval Signature: _____

FDF-600 2011